BABESIOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 52135 (5-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

ISDH Action: ○ A case ○ Not a case

Last Name

First Name **MI** **Phone Number** ___ - ___ - ____

Number & Street Address

City **State** **ZIP Code** ____ - ____

County **Date of Birth** __ / __ / ____ **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** ___ - ___ - ____

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City **State** **ZIP Code** ____ - ____

Section 2. Clinical Information

Symptoms (check all that apply):

- ○ Malaise
- ○ Fatigue
- ○ Anorexia
- ○ Fever ___.__ *(degrees)*
  - ○ Sustained
  - ○ Intermittent
- ○ Chills
- ○ Headache
- ○ Myalgia
- ○ Arthralgia
- ○ Nausea
- ○ Vomiting
- ○ Abdominal Pain
- ○ Dark Urine
- ○ Sore Throat
- ○ Cough
- ○ Photophobia
- ○ Conjunctival Injection
- ○ Rash
- ○ Petechiae
- ○ Splinter Hemorrhages
- ○ Increased Liver Enzymes
- ○ Ecchymoses
- ○ Splenomegaly
- ○ Hepatomegaly
- ○ Splenectomized
- ○ Thrombocytopenia
- ○ Hemolytic Anemia
- ○ Erythrocyte Sedimentation Rate: ___
- ○ Leukocyte Count: ____
- ○ Depression
- ○ Other, specify:

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Section 2. Clinical Information (continued)

Date of Onset ___/___/___

Duration of Symptoms in Days _____

Date First Positive Specimen Collected ___/___/___

Method of Testing Used:

○ Blood Smear **Results:** ○ Positive ○ Negative ○ PCR (blood) **Results:** ○ Positive ○ Negative
○ Serology

1. IgM Testing

Acute Specimen Taken ___/___/___

Acute Value _____

Convalescent Specimen Taken ___/___/___

Convalescent Value _____

Results:
○ Significant Rise in IgM
○ No Significant Rise in IgM
○ Pending
○ Not Done
○ Indeterminate
○ Unknown

2. IgG Testing

Acute Specimen Taken ___/___/___

Acute Value _____

Convalescent Specimen Taken ___/___/___

Convalescent Value _____

Results:
○ Significant Rise in IgG
○ No Significant Rise in IgG
○ Pending
○ Not Done
○ Indeterminate
○ Unknown

Was the patient also tested for lyme disease?

○ Yes ○ No ○ Unknown

Physician/Hospital that Collected Specimen _____

Physician/Hospital Address _____

City _____ **State** _____ **ZIP Code** _____-_____

Physician/Hospital Phone _____-_____-_____

Was the patient hospitalized before or during infection?

○ Yes ○ No

If Yes, admission date: ___/___/___

Discharge date: ___/___/___

Hospital: _____

Did patient die?

○ Yes ○ No

1. Did patient receive blood or blood product within 60 days prior to onset? ○ Yes ○ No

2. Did patient donate blood or blood product within 30 days prior to onset? ○ Yes ○ No

3. Was patient an organ recipient or donor within previous 60 days? ○ Yes ○ No

4. Was patient pregnant at the time of illness? ○ Yes ○ No

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Section 3. Risk Factors

Patient's home setting:

○ Urban ○ Suburban ○ Rural

During the eight weeks prior to symptoms, did the patient:

Engage in outdoor activities at home?

○ Yes ○ No

If Yes, describe

Date ___/___/___

Engage in any of the following activities (check all that apply)?

○ Camping ○ Hiking ○ Fishing ○ Picnicking ○ Hunting

If so, where

Date ___/___/___

Travel to recreational areas within county of residence?

○ Yes ○ No

If Yes, where

Date ___/___/___

Travel outside of county of residence but within Indiana?

○ Yes ○ No

If Yes, where

Date ___/___/___

Travel outside of Indiana?

○ Yes ○ No

If Yes, where

Date ___/___/___

Stay overnight away from home?

○ Yes ○ No

If Yes, where

Date ___/___/___

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Section 3. Risk Factors (continued)

During the four weeks prior to symptoms, did the patient:

Sustain any known tick bites?

○ Yes ○ No

__ __ / __ __ / __ __
If Yes, date

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

__ __ __ - __ __ __ - __ __ __ __ __ __ __ / __ __ / __ __
Phone Number **Date**